(3) May require that the recipient seek to redress the problem through use of the organization's grievance process prior to a State agency determination in a disenrollment for cause request, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when utilized, must be completed in time to permit the enrollee to disenroll no later than the first day of the second month after the month the disenrollment request was made. If the organization, as a result of the grievance process, approves an enrollee's request to disenroll, the State agency is not required to make a determination in the case.

(f) The State agency must make a determination and take final action on the recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date that agency action was required.

(g) An agency which restricts disenrollment under paragraph (b)(2) of this section must also—

(1) Establish an appeal procedure for enrollees who disagree with the agency's finding that good cause does not exist for disenrollment.

(2) Require the organization to inform recipients who are potential enrollees prior to enrollment of their disenrollment rights; and

(3) Require the organization to notify enrollees of their disenrollment rights under this section—

(i) At least 30 days before the start of each new period of enrollment; and

(ii) No less than twice per year.

[48 FR 54020, Nov. 30, 1983, as amended at 53 FR 12016, Apr. 12, 1988; 55 FR 23744, June 12, 1990; 55 FR 33407, Aug. 15, 1990]

§ 434.28 Advance directives.

A risk comprehensive contract with an HMO must provide for compliance with the requirements of subpart I of part 489 of this chapter relating to maintaining written policies and procedures respecting advance directives. This requirement includes provisions to inform and distribute written information to adult individuals concerning policies on advance directives, including a description of applicable State law. Such information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law.

[60 FR 33293, June 27, 1995]

§ 434.29 Choice of health professional.

The contract must allow each enrolled recipient to choose his health professional in the HMO or the PHP to the extent possible and appropriate.

§ 434.30 Emergency medical service.

If the contract covers emergency medical services, it must—

(a) Provide that all covered emergency services are available 24 hours a day and 7 days a week, either in the contractor's own facilities or through arrangements, approved by the agency, with other providers;

(b) Specify the circumstances under which the emergency services will be covered when furnished by a provider with which the contractor does not have arrangements, including at least the following circumstances:

(1) The services were needed immediately because of an injury or sudden illness; and

(2) The time required to reach the contractor's facilities, or the facilities of a provider with which the contractor has arrangements, would have meant risk of permanent damage to the recipient's health; and

(c) Specify whether it is the contractor, or the agency, that will make prompt payment for covered emergency services that are furnished by providers specified in paragraph (b) of this section.

§ 434.32 Grievance procedure.

The contract must provide for an internal grievance procedure that—

(a) Is approved in writing by the agency;

(b) Provides for prompt resolution; and

(c) Assures the participation of individuals with authority to require corrective action.